


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44E232	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2014
NAME OF PROVIDER OR SUPPLIER BLEDSOE COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	INITIAL COMMENTS Stories: 1 Construction Type: III (200) Constructed: approx. 1978 Fully Sprinkled Y Certified beds: 50 Census: 40	K 000	<div style="border: 2px solid black; padding: 5px; text-align: center;"> POC ACCEPTED APR 7 2014  </div>	4/10/14	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to protect corridor openings. Findings include:	K 018			
			A). WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE? 1. Waste can was removed immediately at the door of room 124 by the Maintenance Supervisor/Safety Officer on March 20, 2014. 2. A new latch for the linen supply door was installed by the Maintenance Supervisor/ Safety Director on March 21, 2014.		

continued -

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Stephanie Bunt

TITLE

Administrator

(X6) DATE

4/4/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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OMB NO. 0938-0301

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K 000	INITIAL COMMENTS Stories: 1 Construction Type: III (200) Constructed: approx. 1978 Fully Sprinkled Y Certified beds: 50 Census: 40	K 000			
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to protect corridor openings. Findings include:	K 018	B). HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE? 1. Door at Room 124 - Failure to properly maintain corridor doors /openings potentially increases the risk to all residents. A Staff in- service was conducted by the Maintenance Supervisor/Safety Director on March 21, 2014, regarding the importance of proper closing of all doors. 2. Door at Linen Supply Room - Failure to properly maintain corridor doors/openings potentially increases the risk to all residents. Maintenance Supervisor will routinely monitor all doors in the facility to ensure that all doors are provided with a means suitable for keeping the doors closed. <i>Continued -</i>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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K 000	INITIAL COMMENTS Stories: 1 Construction Type: III (200) Constructed: approx. 1978 Fully Sprinkled Y Certified beds: 50 Census: 40 NFPA 101 LIFE SAFETY CODE STANDARD	K 000			
K 018 SS=D	Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to protect corridor openings. Findings Include:	K 018	C.) WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR? Maintenance Supervisor/Safety Director will routinely monitor and continue to in-service all Staff to ensure that all doors in the facility are properly closed and free from obstructions. D.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR? Maintenance Supervisor/Safety Director will routinely monitor all doors in the facility to ensure that there are no obstructions to prevent proper closing of all doors and that all latches work properly.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

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K 018	Continued From page 1 On 3/20/2014: 1.The door at room 124 was obstructed from closing by a waste can. 2.The door at the Linen Supply room did not latch. The Maintenance Supervisor acknowledged the findings when the deficiencies were identified. Ref: 2000 NFPA 101 Section 19.3.6.3.2, 19.3.6.3.3 Failure to protect corridor doors/openings increases the risk of death or injury due to smoke/fire. NFPA 101 LIFE SAFETY CODE STANDARD	K 018			
K 022 SS=D	Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to mark the means of egress with signage. Findings include:	K 022	B). HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE? All residents will be potentially affected of failure to identify the exits, increasing injury due to fire/smoke or other emergencies. Lighted directional signs were ordered and received for these exits by the Maintenance Supervisor/Safety Director. Project will be completed by April 30, 2014.		

Continued

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K 022	Continued From page 2 On 3/20/2014, the exit access from the door near the chapel and the door near room 126 was not identified with directional sign leading to the exit which is a gate near the laundry. There is not an exit sign at the gate. The Maintenance Supervisor acknowledged the finding when the deficiency was identified. Ref: 2000 NFPA 101 Section 19.2.10.1, 7.10.1.1, 7.10.1.4 Failure to identify the exit access and exits increases the risk of death or injury due to fire/smoke or other emergencies. The deficiency affected 1 exit.	K 022	D.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR? Maintenance Supervisor/Safety Director will routinely monitor the facility to ensure that all exit access is identified with directional signage.		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the	K 056	K 056 A).WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE? Maintenance Supervisor contacted Simplex Grinnell Company. Inspectors came to facility on April 1, 2014 to measure for new standard sprinklers for Resident Rooms 120, 121, 122, and 126. Project to be completed by April 30, 2014		4/30/14

Continued

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STREET ADDRESS, CITY, STATE, ZIP CODE 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367		
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K 056	<p>D.) HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>Maintenance Supervisor/Safety Director will ensure that all sprinklers, when necessary to be replaced, have the same thermal sensitivity in each room.</p>	
K 066		

Facility ID: TN0401

If continuation sheet Page 4 of 7

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K 056	<p>Continued From page 3</p> <p>facility failed to properly install the sprinkler system.</p> <p>Findings include: On 1/28/2014, there were compartments (rooms) with a mix of standard (SR) and quick (QR) response sprinklers. Resident rooms 120, 121, 122, 126 had 2 SR sprinklers and 1 QR sprinkler. There is not a draft stop separating the SR sprinklers from the QR sprinklers.</p> <p>Compartments (rooms) are required to have sprinklers of the same thermal sensitivity.</p> <p>The Maintenance Director acknowledged the findings when the deficiencies were identified</p> <p>Ref: 2000 NFPA 101 Section 19.1.6.2, 19.3.5.1, 9.7.1.1 1999 NFPA 13 Section 5-3.1.5.2, 7.2.3.2.4</p> <p>Failure to properly install sprinklers of the same thermal sensitivity increases the risk of death or injury due to fire.</p>	
K 066 SS=D	<p>The deficiency affected 4 resident rooms and 1 of 4 smoke compartments in the facility.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING</p>	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: IN2221

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K 066	<p>Continued From page 4 or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a self-closing metal container disposal of ashtray contents/cigarette butts at the smoking area.</p> <p>Findings include:</p> <p>On 3/20/2014, the trash can at the smoking area had paper/foam trash and cigarette butts in it.</p> <p>The Maintenance Supervisor acknowledged the finding when the deficiency was identified.</p> <p>Ref: 2000 NFPA 101 Section 19.7.4</p> <p>Failure to provide the required receptacles at smoking areas increases the risk of death or injury due to smoke/fire.</p>	K 066	<p>K 066</p> <p>A).WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?</p> <p>Maintenance Supervisor/Safety Director placed an all metal self-closing container at the smoking area on March 28, 2014.</p> <p>B). HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</p> <p>All residents have the potential to be affected. Metal container with self-closing cover into which ashtrays/ cigarette butts can be emptied, was placed at smoking site by Maintenance Director on March 28, 2014. This will reduce the risk of injury due to smoke/fire.</p> <p><i>Continued</i></p>	4/30/14	

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K 067 K 067 SS=D	<p>Continued From page 5</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to test HVAC equipment.</p> <p>Findings include:</p> <p>On 3/18/2014, the facility could not provide documentation of the required 4 year testing of the dampers.</p> <p>At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary. Installed dampers are required to be maintained.</p> <p>The Maintenance Supervisor acknowledged the finding when the deficiency was identified and verified that dampers are installed in the ducts.</p> <p>Ref: 2000 NFPA 101 Section 19.5.2.1, 9.2.1, 4.6.7 1999 NFPA 90A Section 3-4.7</p> <p>Failure to test the HVAC system as required increases the risk of death or injury due to smoke.</p>	K 067 K 067	<p>K 067</p> <p>A). WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?</p> <p>Maintenance Supervisor/Safety Director has scheduled an inspection of the HVAC equipment with Morgan Electric Company. All dampers will be checked to verify that they fully close. Inspection to be completed by April 30, 2014.</p> <p>B). HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?</p> <p>All residents have the potential to be affected. Maintenance Supervisor will schedule Morgan Electric to conduct a testing of the HVAC system every four years to ensure the dampers are properly maintained.</p> <p><i>Continued</i></p>	4/30/14	